

U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)



Issue Date: 09 November 2006

CASE NO.: 2004-BLA-5720

In the Matter of:

S.P.W.,
Claimant,

v.

PEABODY COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Larry Rowe, Esquire
For the Claimant

Paul E. Frampton, Esquire
For the Employer

Before: Stephen L. Purcell
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under the “Black Lung Benefits Act,” Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901, *et seq.* (hereinafter referred to as “the Act”), and applicable federal regulations, mainly 20 C.F.R. Parts 718 and 725 (“Regulations”).

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.¹

A formal hearing was conducted in Charleston, West Virginia on December 1, 2005 at which all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations.²

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

ISSUES

The contested issues are:

1. Whether Claimant has established a material change of condition pursuant to § 725.309;
2. Whether Claimant has pneumoconiosis;
3. Whether Claimant's pneumoconiosis arose at least in part out of coal mine employment;
4. Whether Claimant has a totally disabling pulmonary impairment; and
5. Whether Claimant's total disability is due to pneumoconiosis. DX 29; Tr. 5-6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background³

Claimant, S.P.W., filed his first claim for Black Lung benefits on January 18, 1980. DX 1. On December 5, 1980, the claims examiner issued a "Notice of Initial Findings" in which he concluded that Claimant was entitled to benefits and identifying Armco, Inc. as the potentially liable operator. DX 1 at 272-274. Armco thereafter filed a notice of controversion with respect to the claim. *Id.* at 266. The claim was thereafter forwarded to the Office of Administrative Law Judges on May 14, 1981 for a formal hearing. *Id.* at 234. A formal hearing was held before Administrative Law Judge Virginia Mae Brown on March 24, 1982 in Logan, West Virginia, and

¹ The following abbreviations have been used in this opinion: DX = Director's exhibits; EX = Employer's exhibits; CX = Claimant's exhibits; Tr. = Transcript of the hearing; BCR = Board-certified radiologist; and B = B-Reader.

² At the hearing, Director's exhibits 1 through 32 were admitted into evidence. Tr. 7. Claimant's exhibits 1, 3-7, and 9 were also admitted into evidence, as were Employer's exhibit 1-5, 7-13, 15-17. Tr. 17-51. Claimant filed his closing brief on February 6, 2006. Despite having been granted an extension of time, Employer did not file a closing brief, and the record is now closed.

³ Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (*i.e.* March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in West Virginia this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989).

Judge Brown thereafter issued a decision dated January 28, 1983 denying benefits based on her conclusion that, although Claimant had established that he suffered from pneumoconiosis, he was not totally disabled by the disease. *Id.* at 114-58; 82-91. Claimant and the Director, Office of Workers' Compensation Programs thereafter appealed the decision, and the Benefits Review Board issued a decision dated April 25, 1985 affirming the decision inasmuch as it was supported by substantial evidence. *Id.* at 36-38.

Claimant filed his second claim for benefits on December 2, 1991. DX 2. On March 11, 1992, the claims examiner denied the claim as Claimant failed to establish total disability or that there was a material change in conditions since the previous claim was denied. Claimant filed a request for a formal hearing, and the claims examiner thereafter issued a Notice of Claim informing Peabody Holding Company, Inc. that it had been identified as the putative responsible operator. Peabody subsequently filed a notice of controversion, and the claim was forwarded to the Office of Administrative Law Judges on August 3, 1992. Administrative Law Judge Reno E. Bonfanti held a formal hearing on January 25, 1993 in Charleston, West Virginia, and he thereafter issued a decision and order dated July 20, 1993 denying the claim based on Claimant's failure to establish total disability due to pneumoconiosis and a material change in his condition since the prior denial. Judge Bonfanti's decision was appealed by Claimant, and the Board issued a decision dated April 26, 1995 affirming that decision. DX 2.

Claimant filed his third claim for benefits on March 1, 2000. In a Notice of Claim dated April 6, 2000, the claims examiner identified Peabody Coal Company as the putative responsible operator. Peabody's counsel thereafter filed a notice of controversion, and on May 24, 2000, the claims examiner informed Claimant that his claim was denied. Additional evidence was thereafter submitted and a Proposed Decision and Order issued by the District Director on November 27, 2000 denied the claim because Claimant had failed to establish that he was totally disabled or that there was any material change in condition since the prior denial DX 3.

Claimant filed his fourth and current claim for benefits on May 16, 2002. DX 5. The claims examiner issued a Notice of Claim dated January 23, 2003 again identifying Peabody Coal Company as the putative responsible operator, and Peabody again filed a notice of controversion. DX 16; DX 18. On September 30, 2003, the District Director issued a Proposed Decision and Order awarding benefits. DX 24. Peabody thereafter filed a request for a formal hearing, and the case was transferred to the Office of Administrative Law Judges on February 4, 2004. DX 25; DX 29. The case was originally scheduled for hearing before Administrative Law Judge Richard A. Morgan, who continued the hearing at Employer's request by order dated October 22, 2004. A hearing was then scheduled before Administrative Law Judge Daniel L. Leland, but the case was again continued, this time at Claimant's request, in an order dated May 18, 2005. A third hearing was thereafter scheduled before the undersigned Administrative Law Judge and held on December 1, 2005 in Charleston, West Virginia.

Claimant testified that he had been an underground coal miner for more than 30 years and had worked at the same coal mine (Number 8 mine, Robin Hood) in Boone County, West Virginia the entire time. Tr. 58-59. He further testified that the mine had been operated by various companies during that period, and stated the last operator of the mine was Peabody Coal Company. Tr. 59. According to Claimant, he first went to work at the mine on July 17, 1953,

and stopped working there on February 26, 1986. Tr. 59-60. Claimant stated that he operated various equipment during his employment at the mine including a roof bolter which he ran for about six to ten years. Tr. 60. He worked five or six days a week, eight hours a day, and was black from coal dust when he left the mine. Tr. 60-61. The last job he had in the mine was that of a “motorman.” Tr. 60. Claimant testified that whenever the motor ran off the tracks, he had to use “big jacks, [and] big chains” to get it back on the tracks, and it was “just brute work – heavy, hard work.” Tr. 61. He could no longer perform that job because of his problems breathing. He further described his job as follows:

Well, there was lifting them big jumpers, jacks, trying to get the motor back on, and had big 20 ton cars and they were loaded with coal. If one of them got off, I had to get off and try to jack it back on the track or pull it, or back it up to get jumpers under it, to get back on the track.

Tr. 62.

Claimant testified that his breathing had gotten worse during the past three or four years. Tr. 62. He denied that he had ever been diagnosed with tuberculosis. Tr. 63. He further testified that he had had “lots of surgeries, seen a lot of doctors, and . . . never had one to say anything like that [about having tuberculosis].” Tr. 63. He had a tuberculosis test at Boone County Health Department which was negative. *Ibid.* Claimant has had open heart surgery, and surgeries for colon cancer, an ulcerated stomach, and his gall bladder. *Ibid.* He was hospitalized for several days at Beckley Hospital for a lung condition in 2000, and none of the treating physicians indicated that he ever had tuberculosis. Tr. 63-64.

Claimant has not worked since 1986, when he retired because he was disabled. Tr. 64. He filed for disability benefits with the Social Security Administration. *Ibid.* He underwent open heart surgery in January 1993, and was diagnosed with colon cancer about a year later. Tr. 65. At the time of the hearing, Claimant was 75 years old. Tr. 66. He was on medication for high blood pressure, used inhalers and a Nebulizer, was not receiving any ongoing treatment for colon cancer, and was not on medication for his heart. *Ibid.*

Medical Evidence

The medical evidence submitted in connection with Claimant’s three earlier claims has been adequately summarized in the prior decisions by Administrative Law Judges Brown and Bonfanti and the Benefits Review Board, and those descriptions are incorporated herein by reference. DX 1-3. The medical evidence submitted in connection with the present claim consists of the following:

Chest X-rays

Exhibit Number	Date of X-ray	Physician/Qualifications	Film Quality	Diagnosis
DX 13	5-30-02	Patel/BCR,B	2	Parenchymal changes consistent with pneumoconiosis; 1/2 profusion of r/q small opacities in upper and mid lung zones; type B large opacities.
DX 13	5-30-02	Binns/BCR,B	1	Quality reading only
EX 4	5-30-02	Wheeler/BCR,B	2	Parenchymal changes consistent with pneumoconiosis; 0/1 profusion of q/q small opacities in upper and mid lung zones; no large opacities. ⁴
EX 2	3-13-03	Scatarige BCR,B	2	Parenchymal changes consistent with pneumoconiosis; 0/1 profusion of t/q small opacities in upper and mid lung zones; no large opacities. ⁵
DX 12	6-17-03	Gaziano/B	1	Parenchymal changes consistent with pneumoconiosis; 1/2 profusion of q/r small opacities in upper and mid lung zones; type B large opacities. ⁶
CX 9	6-17-03	Smith/BCR,B	1	Parenchymal changes consistent with pneumoconiosis; 2/3 profusion of r/q small opacities in all lung zones; type B large opacities. ⁷

⁴ Dr. Wheeler noted, *inter alia*, in the comment section of his report that this x-ray showed “moderate diffuse fibrosis subapical portion upper lobes, distortion and elevation left hilum and linear fibrosis left apex with left apical pleural thickening and minimal nodular infiltrates which CT scan showed are in superior segments lower lobes and lateral [right upper lung] and mid lung probably mixed with small calcified granulomata compatible with TB at least partly healed. Tiny calcified granuloma left lower lateral lung compatible with healed TB or histoplasmosis. . . . This is a single PA view showing some small nodules in mid lungs but prior CT scan confirmed there [sic] were in superior segments lower lobes which is a common site for TB. This case shows the importance of CT scans and limitations of a PA view.”

⁵ Dr. Scatarige noted, *inter alia*, in the comment section of his report that he observed scattered, peripheral round opacities in both upper lungs with infiltrates in the apex and a few calcified granulomata in the left lung. He further stated: “I favor TB of uncertain activity rather than pneumoconiosis.” EX 2.

⁶ In a narrative report dated June 17, 2003, Dr. Gaziano wrote that this x-ray showed shadows in both upper lung zones that he believed represented complicated pneumoconiosis. He further wrote, however, that these shadows may also represent other processes such as old tuberculosis, and he recommended that Claimant see his personal physician for further evaluation. DX 12.

⁷ In a narrative report dated November 9, 2005, Dr. Smith wrote that this x-ray showed numerous small pulmonary parenchymal opacities in the lung fields bilaterally, most numerous in the upper lobes. He further noted that, because of the high concentration of these opacities in the upper lobes, “there is evidence of a coalescence of these small pneumoconiotic nodules and there are large pulmonary parenchymal opacities in the upper lobes, which are classified as B based on size.” CX 9. Dr. Smith also noted the presence of bullae in the lung apices bilaterally. It was his opinion that the x-ray supported a diagnosis of advanced complicated occupational pneumoconiosis.

EX 5 ⁸	6-17-03	Scott/BCR,B	2	Parenchymal changes consistent with pneumoconiosis; 1/1 profusion of q/r small opacities in upper and mid lung zones; no large opacities. ⁹
EX 17 ¹⁰	6-17-03	Scatarige, BCR,B	2	Parenchymal changes consistent with pneumoconiosis; 1/1 profusion of q/r small opacities in upper and mid lung zones; no large opacities.
EX 3	5-12-04	Scott/BCR,B	2	Parenchymal changes consistent with pneumoconiosis; 0/1 profusion of t/q small opacities in upper and mid lung zones; no large opacities. ¹¹

Pulmonary Function Studies

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify?
DX 13	5-30-02	71	69"	2.45 3.17*	77	3.52 4.13*	No No
DX 12	6-17-03	72	68"	2.94	75	4.12	No
EX 9	3-19-03	72	68"	3.05 3.25*		4.20 4.30*	No No
CX 4	3-30-04	73	68"	2.70 2.92*		3.70 3.76*	No No
EX 10	5-12-04	73	68"	2.81 3.04*		3.99 4.04*	No No

*Post-bronchodilator

⁸ In response to Dr. Gaziano's interpretation of the June 17, 2003 x-ray, Dr. Scott wrote in a letter dated October 17, 2005, that "[t]he apical predominance of the infiltrates on the chest films, the presence of linear scarring extending to the pleura and the presence of calcified granulomata all favor TB over silicosis/CWP." EX 15.

⁹ Dr. Scott noted, *inter alia*, in the comment section of his report that there was hyperinflation of the lungs compatible with emphysema, apical infiltrates, fibrosis and scattered calcified granulomata compatible with TB "at least partially healed," and densities noted in section 2.B of the report "may well also be due to TB but cannot [rule out] silicosis/CWP."

¹⁰ In the comment section of his report, Dr. Scatarige noted, *inter alia*, that "upper lobe infiltrates extend to pleura, C/W TB – Need clinical/correlation." EX 17. He further noted there were "small round opacities upper & middle 1/3, some calcified – granulomatous disease (TB, histoplasmosis) vs pneumoconiosis or both." *Ibid*.

¹¹ Dr. Scott noted, *inter alia*, in the comment section of his report that there were "apical infiltrates extending to pleura – compatible with TB, unknown activity. Few calcified granulomata, same etiology . . ." EX 3. He also submitted a "rehabilitative" report in which he wrote, *inter alia*, that "[t]he apical predominance of the infiltrates on the chest films, the presence of linear scarring extending to the pleura and the presence of calcified granulomata all favor TB over silicosis/CWP." EX 15. He further noted that he could not "exclude a small component of silicosis/CWP, but the majority of the disease is most compatible with TB . . . [and] not compatible with complicated pneumoconiosis." *Ibid*.

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify?
DX 13	5-30-02	82.4	39.4	No
		88.0*	39.2*	No
EX 12 ¹²	3-19-03	101	33.0	No
		114*	27.0*	No
CX 3	3-30-04	92.0	34.0	No
EX 11 ¹³	5-12-04	111	34.0	No
		117*	28.0*	No

*Exercise

Medical Reports

Dr. Charles E. Porterfield

The medical report of Dr. Porterfield is dated June 18, 2002 and appears at DX 13. Dr. Porterfield examined Claimant on May 30, 2002 on behalf of the U.S. Department of Labor. He reviewed Claimant's occupational history, noting that his last coal mine employment was in 1986 as a motorman. He also noted Claimant's family history, including a brother with heart disease and a sister with cancer, and a patient history of pneumonia in the 1980's, attacks of wheezing in 2000, arthritis in the neck and shoulder since 2002, heart disease since 1992, allergies since 2001, and high blood pressure in 1993-94. Dr. Porterfield noted that Claimant was hospitalized in 2000 for left lung bleeding and tested negative for tuberculosis at that time. He also noted that Claimant underwent open heart surgery for a triple bypass in 1992, had 12 inches of his intestines surgically removed in 1993, underwent gall bladder surgery in 1994, and had an ulcer removed in 1983. Smoking history was noted as 3/4 pack per day from 1985 to 2000. Physical examination revealed dyspnea with exertion, hemoptysis in 2000, chest pain, 2 pillow orthopnea, and limitations described by Claimant as an inability to climb, lift, or walk fast due to shortness of breath. Diagnostic test results were noted as including a chest x-ray showing coal workers' pneumoconiosis with a 1/2 profusion in the upper and mid lung zones, a vent study showing asthma, and normal arterial blood gases. Based on the results of his examination, Dr. Porterfield diagnosed asthma as the only cardiopulmonary condition and described the etiology as "probably inherited tendency." He further noted that the asthma caused a 10% impairment prior to bronchodilation and no impairment after bronchodilation.

Dr. Dominic C. Gaziano

The medical report of Dr. Gaziano is dated June 19, 2003 and appears at DX 12. Dr. Gaziano is Board-certified in pulmonary diseases, internal medicine, and critical care medicine,

¹² Dr. Zaldivar noted that exercise was stopped due to shortness of breath and an anaerobic threshold was not reached. He further noted that Claimant reached a heart rate of 76.7% of predicted with an EKG that showed a rate of 114 and normal. Blood gases showed exercise hyperventilation. EX 12.

¹³ Dr. Zaldivar noted that exercise was stopped due to shortness of breath and an anaerobic threshold was not reached. He further noted that Claimant reached a heart rate of 65.1% of predicted with an EKG that showed a rate of 96 and normal. Blood gases showed exercise hyperventilation. EX 11.

and he examined Claimant on June 17, 2003. He reviewed Claimant's occupational history of underground coal mining for over 30 years from 1953 to 1986 and noted a medical history of myocardial infarction and open heart surgery, hypertension since 1992, arthritis of the shoulder, hospitalization for ulcerated stomach, cholecystectomy, and colon surgery. It was noted that Claimant was allergic to some type of breathing medication and was then on Cartia XT, Lipitor and Serevent. Claimant reported a smoking history of ½ pack of cigarettes per day from 1950 to 2000 (25 pack years). Claimant's chief complaints were cough with sputum for the past 10 years, a prior episode of hemoptysis, shortness of breath with any activity, and chest pain when he mowed the lawn. Physical examination revealed that Claimant's lungs were clear to auscultation and percussion, and his heart was regular without murmur, thrill, gallop or cardiac enlargement. A chest x-ray was read as positive in both mid and upper lung zones with a 1/2 profusion and large category B opacities of complicated pneumoconiosis. The x-ray also showed postoperative wire sutures and clips and scattered calcified granulomata. A vent study was normal, although diffusing capacity for carbon monoxide was moderately reduced. Dr. Gaziano diagnosed Claimant as having complicated coal workers' pneumoconiosis with a moderate degree of pulmonary functional impairment which, in his opinion, meets the federal criteria for Federal Black Lung Benefits.

Dr. Gaziano was deposed on May 12, 2005 regarding his opinions in this matter. CX 5. He testified that he has been consulting with the Department of Labor and Social Security Administration since 1969 in Black Lung claims, has been a NIOSH-certified B-Reader since about 1980 or 1981, and has been the Kanawha County, West Virginia Clinician for Tuberculosis since about 1970. *Id.* at 4-7. He is also the TB Director for the Kanawha-Charleston Health Department, and testified that he has "treated more TB than any clinic in the state." *Id.* at 7.

Dr. Gaziano testified that he conducted a pulmonary examination of Claimant and authored a report of that examination on June 19, 2003. *Id.* at 8-9. He performed a pulmonary function test and obtained a chest x-ray at the time of the exam. *Id.* at 10. The pulmonary function test revealed a normal spirometry, normal lung volume, and a moderate diffusion impairment. *Ibid.* The blood count produced by the test was representative of someone who was smoking at the time. *Id.* at 11. With respect to the chest x-ray he performed, Dr. Gaziano testified that it showed occupational pneumoconiosis with a significant profusion of 1/2 small opacities, and large opacities due to complicated pneumoconiosis and progressive massive fibrosis. *Ibid.* He stated the pulmonary function test confirmed the loss of tissue observed on the chest x-ray. *Ibid.*

Dr. Gaziano reviewed, *inter alia*, the deposition testimony of Dr. Wheeler and all the x-rays reviewed by him. *Id.* at 12. As early as 1992, according to Dr. Gaziano, the x-rays revealed "very visible . . . pictures of pneumoconiosis that was moderately advanced." *Ibid.* He further testified:

Later on, he developed some changes in the upper lobe, minimal at first, but pretty representative and associated with disease, which included tuberculosis. Then as the x-rays progressed, the upper lobe lesions or upper lobe density became more pronounced, and it got very, very characteristic of complicated

pneumoconiosis. As a matter of fact, the x-ray in 2004 almost looked almost [sic] identical to the standard B-Read film of complicated pneumoconiosis.

Ibid. Dr. Gaziano had no doubt that Claimant had simple pneumoconiosis which had progressed to significant advanced complicated pneumoconiosis. *Id.* at 13. He further believed that tuberculosis had been ruled out “fairly well clinically.” *Ibid.* He testified:

TB never – never looks like this in the more advanced stage. That’s not to say that he didn’t have TB in addition to complicated pneumoconiosis. These x-rays are not that of TB and they’re not that of cancer. They’re that of complicated pneumoconiosis.

Ibid. Dr. Gaziano also testified that a treatment record dated July 18, 2000, when Claimant was hospitalized, noted that he underwent a bronchoscopy and “bronchial wash” which showed Claimant did not have tuberculosis. *Id.* at 15-17.

With respect to chest x-rays that he reviewed, Dr. Gaziano testified that a March 30, 2004 x-ray showed rounded opacities and two large masses in the upper lung cells. *Id.* at 18. He described “a large mass about as big as a silver dollar in the right upper lobe.” *Ibid.* He further stated that Claimant “has a mass that sort of looks like – I call it cigar stick, and another little mass in the left upper lobe.” *Id.* at 18-19. Another x-ray, dated December 21, 1992, showed a profusion of between 1/1 and 1/2 rounded nodules, and the entire sequence of x-rays reviewed by Dr. Wheeler was, according to Dr. Gaziano, “very, very typical of a progression for complicated pneumoconiosis.” *Id.* at 19-20.

When asked if Claimant’s extensive smoking history was a component of his respiratory disability, Dr. Gaziano testified that 70 percent of people who smoke do not get pulmonary impairment, and Claimant did not have any obstructive breathing impairment due to smoking. *Id.* at 21. He acknowledged, however, that CT scan evidence showed evidence of bullous disease which he believed could be related to both smoking and complicated pneumoconiosis. *Id.* at 21-22. He also stated that complicated pneumoconiosis does not necessarily result in a reduction in lung function. *Id.* at 23-24.

Dr. Gaziano disagreed with Dr. Wheeler’s statement that large opacities of complicated pneumoconiosis would necessarily show up first in the center of the lungs and only spread to the lung periphery thereafter. *Id.* at 26, 36. He did agree with Dr. Wheeler that early silicosis and coal workers’ pneumoconiosis target the central portion and mid and upper lungs whereas tuberculosis affects one or both apices and will frequently cause nodular patterns in the periphery of the upper lobes of one or both lungs. *Id.* at 34-34. According to Dr. Gaziano, Claimant’s early chest x-rays were typical for coal workers’ silicosis which develops after a period of mining for about ten years and which can progress even after leaving the mines. *Id.* at 35-36. With regard to Dr. Wheeler’s comment that there was evidence of calcified granuloma, Dr. Gaziano testified that approximately 80 percent of people over the age of 50 have calcified granuloma in their lungs and it is so common that radiologists typically do not even comment on them. *Id.* at 39. Dr. Gaziano observed approximately six to eight calcified granuloma in Claimant’s films. *Ibid.* He emphatically disagreed with Dr. Wheeler that granulomatous

disease best explained what was shown on Claimant's chest x-rays. *Id.* at 39-40. He also disagreed with Dr. Wheeler's comment that Claimant's x-rays lacked a sufficient background of small nodules accompanying the large masses of complicated pneumoconiosis, and testified that "just about every radiologist that read this man's x-rays [would disagree with that statement]." *Id.* at 50. Dr. Gaziano did not believe, as Dr. Wheeler did, that it was necessary to obtain a tissue sample from the lungs in order to render a proper diagnosis regarding complicated pneumoconiosis. *Id.* at 53.

According to Dr. Gaziano, any physician who suspects a patient has tuberculosis is required by law to inform the patient and the State Health Department. *Id.* at 55-56. Bronchial washings and sputum tests done on Claimant in Beckley in 2000 were negative for tuberculosis. *Ibid.* Such tests are more sensitive for detecting active tuberculosis than a skin test. *Id.* at 67. When an individual suffers from active tuberculosis, he or she is contagious and can spread the disease by airborne means when coughing. *Ibid.* With the advent of antibiotics, approximately 95 percent of patients with the disease are cured. *Id.* at 68.

Dr. Gaziano's opinion that Claimant suffers from complicated pneumoconiosis with massive fibrosis is based on the radiographic evidence he reviewed. *Id.* at 69-70. Pulmonary function testing showed some impairment diffusion, but that result was not a reason for Dr. Gaziano's diagnosis. *Ibid.* According to Dr. Gaziano, a diagnosis of complicated pneumoconiosis is based on radiographic or pathologic evidence, and there was no pathology evidence in this case. *Id.* at 70.

On September 15, 2005, Dr. Gaziano authored a one-page letter in which he reported that he reviewed the results of a skin test performed on Claimant on May 17, 2005 which was reported as being negative. CX 7. Dr. Gaziano wrote:

This means that [claimant] does not have TB and has never had TB. The evidence is overwhelming that the abnormalities seen on [Claimant's] chest x-ray are due to complicated coal workers' pneumoconiosis.

Ibid.

Dr. D. L. Rasmussen

Dr. Rasmussen authored a consultation report dated March 30, 2004 at Claimant's request. CX 1. He noted that Claimant, who was then 73 years of age, reported shortness of breath with exertion more than 20 years ago, significant dyspnea after one flight of stairs, and a chronic, hacking, non-productive cough. *Id.* at 1. Claimant also reported wheezes at night, sleeping with two pillows, and awakening with shortness of breath. He further noted that he had coughed up blood in 2001, was hospitalized, and had a bronchoscopy performed at the time. Dr. Rasmussen reported a past medical history including bleeding peptic ulcer in about 1983, myocardial infarction and arteriosclerotic heart disease in 1992, rectal bleeding in 1993, and hemoptysis in 2001. Claimant underwent stomach surgery in 1983, a laparotomy with partial cholecystectomy in 1993, coronary artery bypass graft in 1992, and cataract surgery in 2004. Family history revealed that Claimant's mother had cancer and his father and brother had

emphysema and black lung. Occupational history noted 33 1/2 years of coal mine employment where Claimant worked as a general inside laborer, shuttle car operator, roof bolter, loading machine operator, shot firer, continuous miner helper, and the last 8-10 years as a motorman. *Id.* at 2.

Dr. Rasmussen's physical examination of Claimant revealed, *inter alia*, normal chest expansion and diaphragmatic excursions, minimally reduced and tubular breath sounds, bilateral lateral fine velcro crackles, and no wheezes. Heart rhythm was regular and there were no murmurs, gallops or clicks. There was no sign of edema or clubbing and peripheral pulses were intact.

Dr. Rasmussen also reported that a chest x-ray had been interpreted by Dr. Manu N. Patel as positive for pneumoconiosis with a profusion of 1/2 r/r opacities throughout all lung zones, "as well as bilateral upper zone retractive [sic] Category B large opacities." *Id.* at 2. An electrocardiogram was within normal limits. *Id.* at 3. Results of a ventilatory function study were, according to Dr. Rasmussen, "normal without significant change following bronchodilator therapy . . . [and] single breath carbon monoxide diffusing capacity was moderately severely reduced." *Ibid.* Resting blood gases were recorded as normal. Claimant prematurely exceeded his anaerobic threshold on a treadmill exercise study and the test was terminated after 3 minutes at 1.8 mph at a 0% grade. Oxygen transfer was normal and Claimant was not hypoxic.

According to Dr. Rasmussen, "[t]hese studies indicate very poor exercise tolerance, but at least moderate loss of lung function as reflected by his reduced single breath carbon monoxide diffusing capacity." He further wrote:

The patient had normal oxygen transfer at very light exercise of short duration, but did have increase in dead space ventilation indicating loss of pulmonary vascularity and consistent with his reduced diffusing capacity.

Ibid. Dr. Rasmussen noted that Claimant had a significant history of exposure to coal mine dust and a chest x-ray which was consistent with complicated pneumoconiosis, Category B. He stated: "It is medically reasonable to conclude the patient has complicated coal workers' pneumoconiosis which arose from his coal mine employment." *Ibid.* He further concluded that Claimant's pulmonary impairment rendered him incapable of performing his last regular coal mine job. *Ibid.*

Dr. George L. Zaldivar

Dr. Zaldivar reviewed various medical records supplied to him by Employer and authored a medical report dated April 19, 2005 describing his findings and conclusions. EX 1. He is Board-certified in internal medicine, pulmonary diseases, sleep disorders, and critical care medicine. He is also a NIOSH-certified B-Reader. *Ibid.* Based on his review of this evidence, Dr. Zaldivar concluded that all pulmonary function testing showed normal spirometry and lung volumes, with consistently low diffusion capacity, although blood gases were never low. *Id.* at 4. According to Dr. Zaldivar, Claimant was actively smoking at the time of the test and diffusion capacity was understandably low because of interference from the carbon monoxide in the

tobacco smoke. *Ibid.* He disagreed with Dr. Rasmussen that there was any impairment disability because of the reduction in diffusion capacity inasmuch as the results of blood gas testing always exceeded the results of the diffusion capacity. *Ibid.* He wrote:

The reason I am stating this is that the diffusion capacity serves the purpose of predicting what the blood gases would be during exercise. What I mean by this is, that if the diffusion capacity is low, the expectation is that the blood gases would also be low during exercise, however the blood gas studies with all of its parameters, such as ventilatory reserve, etc. always supersedes the results of the diffusion capacity. Therefore, if there is a discrepancy between an abnormal diffusion and a normal cardiopulmonary stress test, the cardiopulmonary stress test always is to be used to determine whether or not an impairment exists, because after all it is the ventilation and the blood gases that determine whether an individual is capable of working or not. In this instance, the blood gases and other parameters in the exercise test have been consistently normal. Therefore, physiologically there is absolutely no impairment in the case in spite of the diffusion abnormality, which remains an isolated value without any physiological significance.

Ibid.

Dr. Zaldivar was deposed on August 2, 2005 by Claimant's counsel with respect to his opinions in this case. CX 6. He testified that he previously examined Claimant on four occasions; once each in 1992, 2000, 2003, and 2004. *Id.* at 5. He performed a chest x-ray study during the most recent examination on May 12, 2004 which he determined showed simple pneumoconiosis, mass lesions of complicated pneumoconiosis, and bulla. *Id.* at 5-6. Pulmonary function testing at the time revealed normal spirometry and lung volumes with a mild diffusion abnormality of 63 percent of predicted. *Id.* at 6-7. Pulmonary stress tests and blood gases were "entirely normal during exercise." *Id.* at 7. Dr. Zaldivar found no pulmonary impairment at all despite the x-ray findings of pneumoconiosis. *Ibid.* With respect to the bulla he observed in Claimant's lungs, he testified:

Bulla normally translate into a diagnosis of emphysema. If a pathologist were to do a dissection of the lungs, they would find the bulla, and they would find some emphysema from the smoking. But, physiologically, he doesn't have any problem whatsoever. The lungs have a tremendous reserve, and he proved to be normal when measured.

Id. at 8. Blood gas studies during the last three examinations were normal, while diffusion capacity on each of those occasions was always slightly low. *Id.* 9-10.

Dr. Zaldivar agreed that a miner who has complicated pneumoconiosis could also have normal spirometry and a fairly mildly reduced diffusing capacity. *Id.* at 12. He testified:

Yes. It would not be impossible. That has been well documented. Complicated pneumoconiosis does not necessarily translate into pulmonary impairment. So,

yes, you can have complicated pneumoconiosis and perfectly normal physiological studies.

Ibid. Dr. Zaldivar also acknowledged that a physician could not determine whether masses observed by x-ray were caused by tuberculosis or any other cause. *Ibid.* The only way to diagnose tuberculosis without actually opening the lung would be, according to Dr. Zaldivar, to perform a bronchoscopy or do a skin test. *Id.* at 13. A skin test is not always reliable and there is, he testified, 5 percent of the tuberculosis population who do not respond to a TB skin test even though they carry the disease. *Id.* at 13-14.

On cross-examination, Dr. Zaldivar reiterated that his diagnosis of complicated pneumoconiosis in this case was a radiographic determination. *Id.* at 18. He further testified that he did not do a side-by-side comparison of his 2004 and earlier x-rays, and did not review an x-ray from 1980. *Ibid.* When asked if he would have diagnosed complicated pneumoconiosis “but for [his] own view of the x-rays in this case,” he responded “No.” *Id.* at 19. He acknowledged that he has been a B-Reader since 1976 and reads x-rays in every case where he performs a physical examination. *Id.* at 20.

Dr. Paul S. Wheeler

Dr. Wheeler was deposed by Employer’s counsel on April 26, 2005 with respect to his opinions in this case. EX 13. He testified that he was one of four test subjects for Dr. Russell Morgan at Johns Hopkins Hospital who was asked to create the B-Reader test by NIOSH and the American College of Radiology in the early 1970’s. *Id.* at 5-6. Dr. Wheeler stated that after he passed the B-Reader test he and his colleagues became “an expert panel for two government agencies, the Department of Labor and the Social Security Administration.” *Id.* at 6. He became the Medical Director of the Pneumoconiosis Section at Johns Hopkins Hospital after Dr. Morgan died. *Ibid.*

Dr. Wheeler testified that he reviewed a series of chest x-rays spanning a 24-year period in this case, the earliest dated June 26, 1980 and the latest dated May 12, 2004. *Id.* at 11. He testified that the “first report described a possible infiltrate or fibrosis or a mass in the lower right apex or overlap of clavicle, so I wasn’t sure.” *Ibid.* He “felt there was a probably subtle small nodular infiltrate in the lateral periphery of the upper lobes compatible with TB unknown activity.” *Ibid.* He did not believe it was coal workers’ pneumoconiosis or silicosis because it appeared in the peripheral part of the lung rather than the central part. *Id.* at 11-12. According to Dr. Wheeler:

The periphery is the very edge of the lung which isn’t a primary target for early silicosis or CWP. Early silicosis or CWP target the central portion mid and upper lungs. They can spill to the periphery and go to the apices, but when they do, there’s massive central involvement; whereas, TB quite frequently will involve one or both apices and will oftentimes gives [sic] nodular patterns in the periphery of the upper lungs, of one or both upper lungs.

Id. at 12. He testified that he did not know how long Claimant was a miner and that “silicosis [usually] develops during the active period of mining, particularly when there’s no protection involved.” *Id.* at 12-13. He further testified that the 1980 film was underexposed (Quality 3) which made it difficult to assess the small nodular infiltrate in the lateral periphery of the upper lungs. *Id.* at 13-14.

Dr. Wheeler testified that a 1990 chest x-ray he reviewed showed “[m]oderate small nodular infiltrate in left apex, posterior subapical portion upper lobes, superior segments of the lower lobes.” *Id.* at 14. He stated that “[t]hese are typical places for TB to attack.” *Ibid.* He reiterated that CWP and silicosis begin as small nodular infiltrates symmetrically in the central portion of the mid and upper lungs and then, when the disease progresses, the nodules can coalesce to form larger nodules of complicated coal workers’ pneumoconiosis which only then spread to the periphery of the lung. *Id.* at 14-15. According to Dr. Wheeler, “that’s the only situation I know when they spread peripherally.” *Id.* at 15.

Dr. Wheeler stated that he had “a lot of experience with TB beginning in my pathology residency when I autopsied a patient at Cleveland’s Reserve Lakeside Hospital who was thought to have metastatic breast cancer.” *Id.* at 16. According to Dr. Wheeler, when he performed an autopsy on the woman, “everyone in the hospital was stunned when all I found at autopsy was active TB that had been unsuspected and untreated. It was a shocking event. That focused me on TB as a disease.” *Ibid.* After relocating to Baltimore, Dr. Wheeler’s involvement in diagnosing TB continued when the last remaining TB clinic in the city asked him 15 years ago to begin reading x-rays of its patients. *Id.* at 17. When asked whether tuberculosis was a disease that a person could have and not realize it, he stated that the person “very likely will have a cough, a fever, or night sweats, or some symptoms.” *Id.* at 18. He further stated, however, that “many people with TB self-cure, otherwise none of us would be here [since] our ancestors would have been wiped out by the disease eons ago, maybe even before human beings became human beings because TB was widespread certainly in monkey populations as a worldwide disease.” *Ibid.* Tuberculosis is, according to Dr. Wheeler, the leading infectious disease cause of death in the world. *Ibid.*

Dr. Wheeler reviewed Claimant’s December 21, 1992 chest x-ray which he read as showing q and s small opacities in the mid and upper lungs with a 0/1 profusion. *Id.* at 18-19. He stated that he put a question mark on the report because he thought the “vast majority of it can be or all of it can be granulomas [sic] disease.” *Id.* at 19. The reason he thought it might be TB versus histoplasmosis, another very common granulomatous disease, was because TB “likes the upper lobes and the apices [whereas histoplasmosis generally does not target those areas].” *Ibid.* He testified that the pleura, unlike the lung parenchyma, does not contain alveoli and “silicosis doesn’t involve the pleura because there are no alveoli there.” *Id.* at 19-20. Dr. Wheeler also noted the x-ray revealed “[t]iny calcified granuloma right lower lateral lung” . . . that could be either TB or histo[plasmosis].” *Id.* at 20. He thought some of the granuloma “could be” coal workers’ pneumoconiosis, but he testified:

[T]he pattern is asymmetrical and usually pneumoconioses are perfectly symmetrical. It is mainly subapical, in other words, out of the strike zone, high,

and in the lower apices, which would be well out of the strike zone for CWP. It involved the pleural [sic] and that's typical of granulomatous disease.

Id. at 20-21. He further testified that the quality of this x-ray was light (Quality 3) and he would recommend a CT scan. *Id.* at 21. According to Dr. Wheeler:

The routine chest x-ray, to use a mining term, overlay on the lungs. There are ribs that are crossed front and back that obscure some of the lung, and then there's soft tissue, and then the heart can obscure part of the lung, the mediastinum can obscure part of the lung. So that's what we get with a routine chest x-ray. Even when we have multiple views, we are being stymied by overlying ribs and soft tissues that degrade the image.

Id. at 21-22. In contrast, he stated, the CT scan "gives you a chance to see what the real lung looks like without overlying ribs and soft tissues." *Id.* at 22.

Dr. Wheeler reviewed an October 4, 1993 chest x-ray obtained during Claimant's hospital stay and read it as showing a profusion of 0/1 with t/q opacities. *Id.* at 22. He said the film quality was very poor (Quality 3) because it was underexposed, and was an AP portable, versus PA, view which was not consistent with ILO classification. *Ibid.*

A March 21, 2000 chest x-ray was interpreted by Dr. Wheeler as q/s opacities in the right mid and upper lung and left upper lung with a 0/1 profusion. *Id.* at 23.

Dr. Wheeler noted there was an August 17, 2000 chest CT scan which he described as a "limited study" with 1 millimeter settings that showed a coronary artery bypass, emphysema with bullous blebs, scarring and pleural fibrosis and calcified granulomata. *Id.* at 24-26. He stated that "[t]he best explanation there is that it was granulomatous disease." *Id.* at 25.

Dr. Wheeler reviewed a chest x-ray and CT scan, both dated May 12, 2004. *Id.* at 26. He observed q/t small irregular opacities in both upper lung zones with a 0/1 profusion and no large opacities. *Ibid.* He again inserted a question mark on the form "because in my mind TB or granulomatous disease is the most likely cause of what this man has in his lungs." *Ibid.* Dr. Wheeler further stated that Claimant had "pleural thickening, all the characteristic features that I would like to see with TB or some of the other granulomatous diseases." *Id.* at 26-27. The CT scan was "nonstandard" and "limited to a small portion of the upper, mid, and lower lungs." *Id.* at 27. It revealed "linear scars in the left apex and a few tiny nodules in portions of the mid and upper lungs" compatible with granulomatous disease. *Id.* at 28.

Dr. Wheeler stated he found no evidence of pneumoconiosis in a March 19, 2003 CT scan which he believed showed evidence of, *inter alia*, "probably healed TB." *Id.* at 29. He also found evidence of moderate emphysema similar to what he observed in the subsequent 2004 CT scan. *Id.* at 30.

Based on his review of all the films he read, Dr. Wheeler opined that Claimant had coronary artery disease that required a coronary artery bypass, emphysema which "presumably"

came from cigarette smoking, and scarring in the apices and upper lungs which “most likely [represents] granulomatous disease as shown by involvement of the pleura, the asymmetrical pattern, and the calcified granulomata.” *Id.* at 30. With respect to pneumoconiosis, Dr. Wheeler testified:

[C]ould some of the nodules in this case be CWP? I guess, but granulomatous disease best explains it. It would be interesting for me to know when he stopped mining, because I know when he was born, 1930, and I know that the disease was just beginning to become apparent in 1980 on poor quality films.

Id. at 30-31.

Dr. Wheeler concluded that Claimant’s lung disease developed between 1980 and 1990, he did not know when Claimant retired, and he did not know what a “motorman” did or how much dust exposure such a worker would have. *Id.* at 31-32. When asked whether there was anything he observed in the films that would lead him to believe Claimant had complicated pneumoconiosis, he testified:

Well, the location of the mass that was seen is in the apex. That’s away from the usual place where we would expect to see the large opacities. Large opacities form from small opacities, and the small opacities are in the central portion mid and upper lungs.

So they’re usually not very far from the hilar and they’re usually bilateral, not necessarily symmetrical but there are usually more than just one large opacity in a person with true complex CWP or silicosis.

Either way, the 5 centimeter mass that’s in this man as of May 12, 2004, is in the posterolateral right apex and subapical portion of the right upper lobe, and it’s involving the pleura, so that’s two strikes against it. One, it’s out of the strike zone for the typical large opacity location, and two, it’s involving the pleura and of course the pleura has no alveoli.

Id. at 33-34.

Dr. Wheeler testified that he read the following chest x-rays and CT scans pertaining to Claimant in this case:

Date of Exam	X-ray or Ct Scan	Comments
June 26, 1980	X-ray	
October 2, 1980	X-ray	
December 14, 1991	X-ray	2 Chest PA views and a lateral view
December 21, 1992	X-ray	Chest PA, Quality 3 (very underexposed)
October 3, 1993	X-ray	Chest PA and lateral views
October 4, 1993	X-ray	

March 21, 2000	X-ray	
June 14, 2000	X-ray	Chest PA view, good quality
August 17, 2000	CT scan	
May 30, 2002	X-ray	Chest PA view
March 19, 2003	X-ray	Chest PA view, Quality 2 (underexposed)
March 19, 2003	CT scan	
June 17, 2003	X-ray	Chest PA and lateral views, Quality 2 (underexposed)
March 30, 2004	X-ray	2 Chest PA views
May 12, 2004	X-ray	Chest PA, Quality 1
May 12, 2004	CT scan	

Id. at 35-36.

Dr. Wheeler reiterated that the three CT scans done by Charleston Area Medical Center that he reviewed were “non-standard” since they included only the lungs and “the standard for pneumoconiosis is, at least in my hospital and virtually every hospital I’ve ever heard of . . . [is] a complete CT scan, top to bottom, apices to below the costophrenic angles, either 5 millimeter thick slices, 6 millimeter thick slices, 8 millimeter thick slices, or 10 millimeter thick slices.” *Id.* at 37. According to Dr. Wheeler, “[y]ou want the lung settings to see the lung detail, . . . [and] the mediastinal settings to see the soft tissue detail and the calcifications, [which are] especially important when you’re looking for coronary calcifications.” *Id.* at 37-38. He also noted that “you never use prone scans on a person for CWP because what you’re looking for is nodules . . . and you have increased lung markings in the back and the lower lobes from lying around on a CT scanner too long. . . . So if a person lies on their back long enough, the back part, the dependent parts of the lungs become more congested with fluid; not pathologically.” *Id.* at 39-40.

Dr. Wheeler acknowledged that he did not have any information that Claimant had ever been treated for TB, and that it was the location of the x-ray and CT scan findings which led him to conclude that Claimant suffered from a granulomatous disease rather than coal workers’ pneumoconiosis. *Id.* at 43. He stated:

Calcified granulomata are either TB or histo[plasmosis]. Those are the only two. The one that goes after the upper lobes and the apices is TB. Histo can give the nodal calcification we see in this case. It can certainly give the one that was in the lower costophrenic angle. Both diseases can be present. They are both disease[s] that were seen in America relatively frequently. Histo is more common than TB, but TB goes after the upper lungs.

I’m quite sure that it’s stable, that it’s no longer communicable because he had a coronary bypass and usually they will not do surgery on somebody with active TB.

Id. at 43-44. Dr. Wheeler acknowledged that some of the findings he observed “could be pneumoconiosis.” *Id.* at 44. He disagreed that it was important for a radiologist to know when a particular claimant had been mining stating “all I need to know is the exposure. I need to know if it’s asbestos, silica, or iron oxides that are inhaled.” *Id.* at 44-45. He indicated that knowing when Claimant stopped mining would be “of interest to me just intellectually . . . because in my experience you don’t develop CWP when you’re no longer mining.” *Id.* at 45.

Dr. Wheeler testified that he would defer to the opinion of clinicians and physicians who evaluated an individual for complicated pneumoconiosis only when they performed a biopsy. *Id.* at 49. He stated:

I don’t know that the clinicians can know what’s going on in the patient just from listening to them or talking to them.

If you look at the ILO guidelines, you’ll see it says, “There’s no x-ray pattern or pulmonary function abnormality or physical abnormality that’s diagnostic of any pneumoconiosis. The definitive diagnosis comes from a biopsy.” There are patterns that are consistent with various pneumoconiosis.

Id. at 50-51.

The primary reason Dr. Wheeler did not diagnose complicated pneumoconiosis in this case is that Claimant “didn’t have very many nodules initially.” *Id.* at 51. He stated: “There was a question of a mass in the right apex initially. That’s the 1980 film.” *Ibid.* He further testified:

Later on in that same area that I was worried about in 1980, there’s a mass and it’s confirmed with a CT scan. It’s out of the strike zone for a large opacity and the central portion of the mid and upper lung zones don’t have anywhere near as many small opacities as the apices and the periphery. The disease involves the pleura. The pleura has no alveoli, so it cannot have silicosis or CWP.

Finally, it has calcified granulomata. Those are one of two things in this country with any frequency. It’s going to be either TB or histoplasmosis and there’s no rule saying you can’t have both.

Id. at 52.

According to Dr. Wheeler, a needle biopsy of the mass in this case would provide a definitive answer to whether the mass was pneumoconiosis or some other disease, and he further stated that it would be very safe since the mass was in the pleura which reduces the risk of a pneumothorax to “almost zero.” *Ibid.* He further testified that he did not believe the mass was cancer, but he could not exclude that possibility. *Id.* at 53. With respect to the location of the mass, Dr. Wheeler clarified that the mass he observed involved both the apex of the lung and the lung pleura. *Id.* at 55. He testified:

The apex is a portion of the lung. It happens to be a relatively small portion of the lung. Like the tip of the iceberg is to the iceberg, that's what the apex is to the lung. It's like the penthouse apartment on a tall building. It's a very small part of the lung.

Ibid. He further stated, however, that the apex was usually attacked by only two diseases; bullous emphysema from cigarette smoking and tuberculosis. *Ibid.*

When asked if a diagnosis of complicated pneumoconiosis was more a clinical finding than a radiological finding, Dr. Wheeler testified "it's a radiologic pattern of a mass greater than a centimeter in diameter with a sufficient background of small nodules." *Id.* at 60. He stated that an individual could not have a large opacity "unless you have a high profusion of background nodules." *Ibid.* Claimant, in Dr. Wheeler's view, did not have a high profusion of background nodules, although "he had significant infiltrates and fibrosis." *Ibid.*

In a supplemental report dated October 18, 2005, Dr. Wheeler responded to Dr. Gaziano's comments regarding his opinions in this case. EX 16. Dr. Wheeler noted that Dr. Gaziano reported that a Department of Health PPD (purified protein derivative) test dated May 17, 2005 showed that Claimant "does not now have TB and never has had TB." *Id.* at 1. According to Dr. Wheeler, Dr. Gaziano also stated that "[t]he evidence is overwhelming that the abnormalities on [Claimant's] chest x-ray are due to complicated coal workers' pneumoconiosis." *Ibid.* Dr. Wheeler disagreed with both of Dr. Gaziano's conclusions.

With respect to Dr. Gaziano's conclusion that Claimant did not have TB, Dr. Wheeler wrote:

Some in the medical profession, usually nurses, may say a positive PPD is "forever" but this is not true. Our immune systems are vital. Birth is partly triggered by the fetus rejecting the mother's placenta and life ends for many when immunity cannot handle bacterial and viral invaders. This makes infectious disease a leading cause of death world wide. [Claimant] is 75. As we age, the immune system becomes less competent and this is only one reason for a negative PPD in a person who has had TB. Other causes for "false" negative PPD are faulty technique in applying and reading the test (which requires an intradermal rather than subcutaneous injection), anergy in people who have other diseases including sarcoid, and simply losing the antibodies and cellular response decades after TB has been self-cured or cured by drugs. My father was a physician and bacteriologist who developed a positive PPD as I recall during his internship at Boston. Years later it converted to negative and at autopsy he had a calcified granuloma in one adrenal, a favorite attack site for TB. A leading bacteriologist at Hopkins tells me she developed a positive PPD in her teens without any symptoms. She was not treated and reverted to negative years later.

As many as 25% of patients on our HIV ward at Hopkins with documented TB by culture have negative PPDs. As a Pathology resident at Western Reserve in Cleveland, I autopsied a woman with a clinical diagnosis of metastatic breast

cancer who died of wide spread unsuspected TB with impressive masses and nodules in both lungs. The theory of why people dying of TB have negative PPDs is that the body is too “wise” to waste its immune reaction on the skin when vital organs are being overwhelmed.

Id. at 1-2.

With respect to Dr. Gaziano’s conclusion based on radiographic evidence, Dr. Wheeler wrote that his review of all the radiologic exams “showed a progression of upper lung disease that began with possible infiltrate, fibrosis, mass or overlapping bone shadows in right apex and probable nodular infiltrates in lateral periphery upper lobes in 1980 to definite masses involving pleural containing calcified granulomata most recent studies.” *Id.* at 2. The most common reasons for these findings, according to Dr. Wheeler, are histoplasmosis and/or TB. *Ibid.* He believed that Claimant had received treatment in the past for TB, and that a review of his older treatment records would confirm this unless the treating physician was sure the upper lung disease was histoplasmosis. *Ibid.* Dr. Wheeler also wrote that most large opacities of CWP developed in drillers working in coal mines without protection before World War II, and he did not know if Claimant was a driller or had used any such protection. *Ibid.* He further noted that large opacities typically form in the central portion of the mid and upper lungs and do not involve the lung pleura because there are no alveoli to trap fine dust particles. *Ibid.* According to Dr. Wheeler, “the masses [in this case] involve pleura and most of the small opacities around them are linear with a minority of small nodules.” *Ibid.* Finally, Dr. Wheeler noted that

there is overwhelming evidence that the masses in [Claimant’s] series of x-rays and CT scans are large opacities of granulomatous disease, most likely TB by location. Histoplasmosis is another strong candidate assuming a “true” negative PPD and no history of a positive PPD. Other granulomatous diseases (sarcoid, Giant Cell arteritis and Wegener’s) are less common and much less likely to self-cure.

Id. at 3. Dr. Wheeler opined that there would be no divergent opinions in this case “if an exact diagnosis had been made early in the disease process, typically by needle or open lung biopsy or bacteriology.” *Ibid.*

Dr. Robert Smith

Dr. Smith authored a one-page report dated November 9, 2005 in which he wrote that he had reviewed a chest x-ray performed on Claimant on June 17, 2003 at Dr. Gaziano’s office. CX 9. Dr. Smith further wrote:

There are numerous small pulmonary parenchymal opacities in the lung fields bilaterally, but most numerous in the upper lobes. These small pulmonary opacities are classified as shape/size r/q, and of profusion 2/3. In addition, because of the high concentration of these opacities in the upper lobes, there is evidence of coalescence of these small pneumoconiotic nodules and there are

large pulmonary parenchymal opacities in the upper lobes, which are classified as B based on size. In addition, bullae in the lung apices bilaterally are present. . . .

Ibid. He also noted that there was mild hyperexpansion of the lung fields consistent with chronic emphysema, and, based on his review of the x-ray, Dr. Smith concluded that Claimant suffered from advanced complicated occupational pneumoconiosis. *Ibid.*

Dr. Smith is Board-certified in nuclear medicine, nuclear cardiology, and radiology, with special competence in nuclear radiology and diagnostic radiology. He is also a NIOSH certified B-Reader. *Ibid.*

CT Scans

Dr. Paul Wheeler interpreted a March 19, 2003 CT scan of Claimant's chest as showing no pneumoconiosis, healed anterior chest surgery for coronary artery bypass, "probably healed TB with moderate irregular and linear scars in left apex involving pleura, few small scars in posterior right apex and small calcified granulomata in apices, hilar nodes and both mid lungs." He further noted that there was evidence of moderate emphysema with blebs in the "right apex > left and small small bilateral scattered subpleural blebs." EX 7.

Dr. William Scott interpreted a May 12, 2004 CT scan of Claimant's chest as showing bilateral upper lung scarring with masses about 5 cm in maximum dimension, calcified granulomata within masses as well as in lung and hilar nodes, thickened pleura with scarring, and emphysema with bullous changes in the lung apices. EX 8. He further wrote: "Changes are most compatible with TB, unknown activity, at least partially healed."

Conclusions of Law

Length of Coal Mine Employment

At the hearing, Employer stipulated to at least 33 years of coal mine employment. Tr. 6. I find that the record supports Employer's stipulation. DX 7; DX 8; DX 24; DX 29. Accordingly, I find that Claimant was employed as a miner for at least 33 years.

Date of Filing and Timeliness

I find that Claimant filed his claim for benefits under the Act on May 16, 2002, and that this subsequent claim is timely. DX 4. *See, e.g., Consolidation Coal Co. v. Director, OWCP [Williams]*, ___ F.3d ___, Case No. 05-2108 (4th Cir. July 13, 2006) (miner's subsequent claim not barred by the three year statute of limitations at 20 C.F.R. § 725.308 despite existence of evidence supporting entitlement submitted in conjunction with prior denied claim); *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (same).

Responsible Operator

The Director determined that Peabody Coal Company was the most recent operator that met all of the requirements of the regulations. DX 16. Although the issue was originally contested by Employer at the time of the hearing, Employer subsequently withdrew its controversion of that issue based on Claimant's testimony and the evidentiary record. Tr. 6, 71. I find that Peabody Coal Company is the properly named responsible operator in this case.

Dependents

I find that Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife Opal Marie. Tr. 69; DX 4.

Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985).

As the trier-of-fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Subsequent Claim

Pursuant to 20 C.F.R. § 725.309(d), any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim. Moreover, if the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one

applicable condition of entitlement. If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim.

Claimant's most recent claim was denied because Claimant failed to establish the existence of a totally disabling pulmonary impairment and that any such disability was caused by his coal mine employment. DX 3. Therefore, if either of these elements can be established by the newly submitted evidence, Claimant will have shown a material change in condition.

Total Disability

A miner shall be considered totally disabled if the irrebuttable presumption described in § 718.304 applies or if the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his usual coal mine work or comparable employment. § 718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that, in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability.

Complicated Pneumoconiosis

Under 20 C.F.R. § 718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if the miner is suffering from complicated pneumoconiosis. Complicated pneumoconiosis is established by x-rays classified as Category A, B, or C, or by an autopsy or biopsy, which yields evidence of massive lesions in the lung or nodules in the lung that would equate to a one centimeter or greater opacity on x-ray. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh all relevant evidence. *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 256 (4th Cir. 2000); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985)..

The newly submitted chest x-ray evidence in this subsequent claim consists of four separate x-rays dated May 30, 2002, March 13, 2003, June 17, 2003 and May 12, 2004, respectively.

The May 30, 2002 film was interpreted by Drs. Patel and Wheeler, both of whom are dually-qualified as Board-certified radiologists and B-Readers.¹⁴ DX 13; EX 4. Dr. Patel diagnosed both simple and complicated pneumoconiosis with type B large opacities. DX 13. Dr. Wheeler read the film as negative for pneumoconiosis.¹⁵ EX 4. Given the comparable qualifications of both physicians, I find this evidence to be in equipoise and thus insufficient to support a finding of complicated pneumoconiosis.

¹⁴ The film was also reviewed by Dr. Binns solely for the purpose of evaluating the quality of the film. DX 13.

¹⁵ Although Dr. Wheeler noted the presence of parenchymal changes consistent with pneumoconiosis, he read the film as showing a profusion of only 0/1 opacities. Category 0/1 demonstrates, at most, only a negligible presence of the disease, and it is insufficient to support a finding of pneumoconiosis under the Act or regulations. See 20 C.F.R. § 718.102(b) ("A chest X-ray classified . . . as Category 0, including sub-categories 0-, 0/0, or 0/1 . . . does not constitute evidence of pneumoconiosis.").

The March 13, 2003 chest x-ray was interpreted only by Dr. Wheeler, who found it negative for pneumoconiosis. EX 2. I thus find this evidence insufficient to support a finding of complicated pneumoconiosis.

The June 17, 2003 chest x-ray was read by Dr. Gaziano, a B-Reader, and by Drs. Smith, Scott and Scatarige, all dually-qualified physicians. DX 12; CX 9; EX 5; EX 17. Both Drs. Gaziano and Smith diagnosed pneumoconiosis with type B large opacities. DX 12; CX 9. Dr. Scott diagnosed pneumoconiosis but found no large opacities, and Dr. Scatarige found the film negative for pneumoconiosis. EX 5; EX 17. At best, the interpretations of this film are in equipoise on this issue, and I thus find that they are insufficient to support a finding of complicated pneumoconiosis.

The one remaining x-ray, dated May 12, 2004, was read as negative for simple and complicated pneumoconiosis by Dr. Scott who, as noted above, is both a Board-certified radiologist and a B-Reader. EX 3. Since there are no contrary readings, I find this evidence insufficient to support a finding of complicated pneumoconiosis.

With respect to the record from the three earlier claims, there are six chest x-rays submitted by the parties either in support of, or opposition to, Claimant's entitlement to benefits.¹⁶

The earliest of the six chest x-rays from the prior claims is a June 26, 1980 film which was interpreted by Dr. Gaziano as positive for pneumoconiosis (1/1) with no large opacities. It was found to be "unreadable" by Dr. Charles D. Smith, a Board-certified radiologist and B-Reader. DX 1. Neither interpretation would thus support a finding of complicated pneumoconiosis.

The record also contains an October 2, 1980 chest x-ray which was read by Drs. Wheeler and Gaziano as positive for simple pneumoconiosis (2/1 and 1/0, respectively) with no large opacities. DX 1. Neither interpretation of this x-ray supports a finding of complicated pneumoconiosis.

The next x-ray is dated December 14, 1991 and was read by Dr. Mohammed I. Ranavaya, a B-Reader, as positive for simple pneumoconiosis (3/3) with no large opacities. DX 2. The same film was read by Dr. Paul Francko, Jr., a Board-certified Radiologist and B-Reader, as positive for simple pneumoconiosis (2/1) with no large opacities DX 2. Although both physicians diagnosed simple pneumoconiosis, neither interpretation supports a finding of complicated pneumoconiosis.

The next chest x-ray is dated October 3, 1993 and was read by three physicians as positive for simple, but not complicated, pneumoconiosis. DX 3. Dr. William Wallace Scott and Dr. Bob Gayler, both of whom are dually-qualified physicians, read the x-ray as 1/2 with no

¹⁶ The record also contains multiple chest x-rays obtained during the treatment of Claimant for various conditions, none of which were conducted and classified in accordance with § 718.102 of the regulations, and these films therefore may not form the basis for a finding of the existence of pneumoconiosis. 20 C.F.R. § 718.202(a)(1).

large opacities, while Dr. Wheeler, also a dually-qualified physician, read the film as 1/0 with no large opacities. None of these interpretations support a finding of complicated coal workers' pneumoconiosis.

The record also contains a chest x-ray dated March 21, 2000 which was read as positive for simple pneumoconiosis by Dr. Shiv Navani (1/1), a Board-certified radiologist and B-Reader, and by Dr. Gaziano, a B-Reader (2/1). DX 3. Dr. M. V. Ranavaya, a B-Reader, read the film as showing both simple pneumoconiosis (3/3) and type A large opacities of complicated pneumoconiosis. DX 3. I find that Dr. Ranavaya's finding of complicated pneumoconiosis is outweighed by the findings of Dr. Gaziano, who is also a B-Reader, and by Dr. Navani, a dually-qualified physician. This x-ray therefore does not support a finding of complicated pneumoconiosis.

The final chest x-ray contained in the prior record is dated June 14, 2000. DX 3. Drs. Gayler and Scott both read the film as positive for simple pneumoconiosis (1/2) with no large opacities, while Dr. Wheeler read the film as positive for simple pneumoconiosis (1/0) with no large opacities. These interpretations do not support a finding of complicated coal workers' pneumoconiosis.

Based on the foregoing, I find that Claimant has failed to establish the existence of complicated pneumoconiosis by a preponderance of the chest x-ray evidence pursuant to 20 C.F.R. § 718.304(a).

Neither Claimant nor Employer has submitted any biopsy evidence in this claim.¹⁷ I thus find that Claimant has failed to establish the existence of complicated pneumoconiosis pursuant to 20 C.F.R. § 718.304(b).

The remaining method by which Claimant may establish that he suffers from complicated pneumoconiosis is under section 718.304(c) of the regulations. That regulation provides that a miner shall be considered totally disabled due to pneumoconiosis when he is suffering from a chronic dust disease of the lung which "[w]hen diagnosed by means other than [chest x-ray or biopsy], would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described." 20 C.F.R. § 718.304(c). Both Claimant and Employer have offered medical opinion evidence relevant to the issue of whether Claimant suffers from complicated coal workers' pneumoconiosis. In addition, Claimant was examined by Dr. Porterfield on May 30, 2002 on behalf of the Department of Labor with respect to this subsequent claim. I find, for the reasons stated below, that the medical opinion evidence supports a finding of complicated pneumoconiosis.¹⁸

¹⁷ Since this is a living miner's claim, there is obviously no autopsy evidence available.

¹⁸ I note that the medical opinions of Drs. Gaziano and Smith are based on their interpretations of Claimant's chest x-ray results. While I have found the x-ray evidence, considered in isolation, does not support a finding of complicated pneumoconiosis, I also find that the favorable medical opinion evidence of record outweighs the contrary x-ray evidence reported on the ILO forms contained in the record and described above. In *McCoy v. Holly Beth Coal Co.*, BRB No. 05-0818 BLA (May 25, 2006) (unpub.), the Board determined that a physician must check a box on the ILO form indicating the presence of an A, B, or C opacity in order for a diagnosis of complicated pneumoconiosis to be made via chest x-ray evidence and that notations in the comment portion of the ILO form cannot constitute findings of complicated pneumoconiosis under the regulations. In this case, none of Employer's

Dr. Porterfield's report of his examination of Claimant on May 30, 2002 lists asthma as the only cardiopulmonary condition established by the evidence obtained during the examination. DX 13. Given his failure to diagnose even simple coal workers' pneumoconiosis, Dr. Porterfield's opinion does not aid Claimant in meeting his burden of proving the existence of complicated pneumoconiosis. However, neither does the opinion weigh against such a finding since it fails to note and discuss highly relevant evidence developed during the examination. First, while the report clearly records that the chest x-ray obtained during the examination was read by Dr. Patel as positive for coal workers' pneumoconiosis, Dr. Porterfield fails to explain why he either agrees or disagrees with that diagnosis. Second, the report inaccurately reports the results of Dr. Patel's reading of the x-ray inasmuch as it ignores the fact that Dr. Patel noted the presence of type B large opacities showing complicated pneumoconiosis. Dr. Porterfield's failure to address Dr. Patel's positive x-ray interpretation, coupled with his inaccurate reporting of those test results, renders his opinion on the issue of whether Claimant suffers from complicated coal workers' pneumoconiosis of little or no value. *See, e.g., Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 532-33 (4th Cir. 1998) (ALJ cannot rely on unexplained medical opinions); *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984) (report may be rejected where basis for opinion cannot be determined); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (report properly discredited where physician fails to explain how underlying documentation supports diagnosis).

Of the five remaining medical opinions in this case, the opinions of Drs. Gaziano, Smith, and Rasmussen support a finding of complicated coal workers' pneumoconiosis, while the opinions of Drs. Zaldivar and Wheeler are to the contrary. I find the opinions of Drs. Gaziano and Smith well documented and well reasoned and entitled to substantial weight. The opinion of Dr. Rasmussen is consistent with those opinions in some respects, but I find that it is less reasoned, and therefore entitled to less weight, than the opinions of Drs. Gaziano and Smith. I also find that the contrary opinions of Drs. Zaldivar and Wheeler are outweighed by the better reasoned and documented opinions of Drs. Gaziano and Smith. The reasons for these findings are set forth below.

Dr. Gaziano performed a physical examination of Claimant on June 17, 2003, and, as part of that examination, he obtained a chest x-ray which he interpreted as positive for pneumoconiosis in both mid and upper lung zones with a 1/2 (few to numerous) profusion of q/r (rounded) opacities and type B large opacities of complicated pneumoconiosis. DX 12. He testified during his May 12, 2005 deposition that he was Board-certified in pulmonary diseases, internal medicine, critical care medicine, and independent medical evaluations for all occupational diseases. CX 5 at 6-7. He further testified that he has been consulting with the

experts who reviewed the newly submitted x-ray evidence checked the box indicating the presence of A, B, or C opacities on their ILO forms, and I must therefore accept their x-ray interpretations as evidence that these films do not support a diagnosis of complicated pneumoconiosis when weighing that evidence under § 718.304(a). However, these same x-rays have been read by highly qualified physicians on both sides as showing the presence of one or more large opacities, and the interpretations of what those opacities represent have been discussed at length by both Claimant's and Employer's experts. While I am obliged by the *McCoy* decision to accept the ILO interpretations of Employer's experts when evaluating the x-ray evidence under § 718.304(a), I am not so constrained when reviewing the medical opinion evidence concerning what physicians observed on Claimant's chest x-rays under § 718.304(c) of the regulations.

Department of Labor and Social Security Administration since 1969 in Black Lung claims, has been a NIOSH-certified B-Reader since about 1980 or 1981, has been the Kanawha County, West Virginia Clinician for Tuberculosis since about 1970, and is the TB Director for the Kanawha-Charleston Health Department. *Id.* at 4-7. He reviewed all the chest x-rays reviewed by Dr. Wheeler in this case, and noted that x-rays as early as 1992 revealed “very visible . . . pictures of pneumoconiosis that was moderately advanced.” *Id.* at 12. He further testified:

Later on, he developed some changes in the upper lobe, minimal at first, but pretty representative and associated with disease, which included tuberculosis. Then as the x-rays progressed, the upper lobe lesions or upper lobe density became more pronounced, and it got very, very characteristic of complicated pneumoconiosis. As a matter of fact, the x-ray in 2004 . . . looked almost identical to the standard B-Read film of complicated pneumoconiosis.

Ibid. Dr. Gaziano also testified that the March 30, 2004 x-ray reviewed by Dr. Wheeler showed rounded opacities and two large masses in the upper lung cells, one of which he described as “a large mass about as big as a silver dollar in the right upper lobe” and the other a “cigar-like” mass in the left upper lobe. *Id.* at 18-19. According to Dr. Gaziano, the entire sequence of x-rays reviewed by Dr. Wheeler was “very, very typical of a progression for complicated pneumoconiosis.” *Id.* at 19-20.

With regard to Dr. Wheeler’s comment that there was evidence of calcified granuloma in Claimant’s x-rays, Dr. Gaziano testified that approximately 80 percent of people over the age of 50 have calcified granuloma in their lungs and it is so common that radiologists typically do not even comment on them. *Id.* at 39. Dr. Gaziano observed approximately six to eight calcified granuloma in Claimant’s films. *Ibid.* He emphatically disagreed with Dr. Wheeler that granulomatous disease best explained what was shown on Claimant’s chest x-rays. *Id.* at 39-40. He also disagreed with Dr. Wheeler’s comment that Claimant’s x-rays lacked a sufficient background of small nodules accompanying the large masses of complicated pneumoconiosis, and testified that “just about every radiologist that read this man’s x-rays [would disagree with that statement].” *Id.* at 50.

With respect to Dr. Wheeler’s conclusion that the large opacities observed in Claimant’s x-rays were tuberculosis or some other granulomatous disease, Dr. Gaziano testified:

TB never – never looks like this in the more advanced stage. That’s not to say that he didn’t have TB in addition to complicated pneumoconiosis. These x-rays are not that of TB and they’re not that of cancer. They’re that of complicated pneumoconiosis.

Ibid. He also testified that a treatment record dated July 18, 2000, when Claimant was hospitalized, noted that he underwent a bronchoscopy and “bronchial wash” which showed Claimant did not have tuberculosis. *Id.* at 15-17, 55-56. Such tests are, according to Dr. Gaziano, more sensitive for detecting active tuberculosis than a skin test. *Id.* at 67. In a supplemental report dated September 15, 2005, Dr. Gaziano further noted that he reviewed the

results of a skin test performed on Claimant on May 17, 2005 which was also negative for tuberculosis. CX 7. Dr. Gaziano wrote:

This means that [Claimant] does not have TB and has never had TB. The evidence is overwhelming that the abnormalities seen on [Claimant's] chest x-ray are due to complicated coal workers' pneumoconiosis.

Ibid.

Dr. Robert Smith, who is a B-Reader and Board-certified radiologist, with special competence in diagnostic radiology, read the June 17, 2003 chest x-ray obtained by Dr. Gaziano as positive for complicated coal workers' pneumoconiosis. CX 9. He observed numerous small pulmonary parenchymal opacities in the lung fields bilaterally, but most numerous in the upper lobes classified as r/q (rounded) with a profusion 2/3 (numerous to very numerous).¹⁹ *Ibid.* He further noted that, because of the high concentration of these opacities in the upper lobes, there was evidence of a coalescence of these small pneumoconiotic nodules and there were large pulmonary parenchymal opacities seen in the upper lobes which he classified as type B because of their size. *Ibid.* Based on his review of the x-ray, Dr. Smith concluded that Claimant suffered from advanced complicated occupational pneumoconiosis. *Ibid.*

Dr. Rasmussen examined Claimant and prepared a consultation report dated March 30, 2004.²⁰ CX 1. Based on his review of the objective test results obtained during the examination, including the report of Dr. Patel's reading of the May 30, 2002 chest x-ray, he concluded that Claimant had complicated pneumoconiosis which arose from his coal mine employment and that Claimant's pulmonary impairment rendered him incapable of performing his last regular coal mine job. *Id.* at 3. However, neither the blood gas study results nor the pulmonary functions study results support a finding of total disability under the Department of Labor's regulations, and Dr. Rasmussen did not explain how the results he obtained, including what he described as a "moderately severely reduced" diffusing capacity, would support such a conclusion.

In contrast to the opinions of Drs. Gaziano, Smith, and Rasmussen, the opinions of Drs. Zaldivar and Wheeler do not support a finding of complicated pneumoconiosis.²¹

¹⁹ The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Similarly, a reading of 0/0 means the doctor found no opacities and did not see any marks that would cause him or her to seriously consider category 1.

²⁰ Dr. Rasmussen's curriculum vitae was not included with the report, nor was he deposed with respect to his opinions in this case.

²¹ I have previously noted that Dr. Scott has interpreted various radiologic test results on behalf of Employer, and Employer has submitted, in addition to Dr. Scott's ILO forms recording his interpretations of the x-ray tests, a one-page narrative report recording his findings after reviewing a May 12, 2004 CT scan and a one-page "rehabilitative" report regarding his interpretation of an October 17, 2005 chest x-ray. EX 8; EX 15. Since these reports are not

Dr. Zaldivar is a NIOSH-certified B-Reader and is Board-certified in internal medicine, pulmonary diseases, sleep disorder medicine, and critical care medicine. EX 1. The April 19, 2005 report prepared by him is based on a review of medical records forwarded to him by Employer's counsel, relates solely to the issue of whether Claimant is totally disabled from a respiratory or pulmonary standpoint, and is entirely silent with respect to the presence or absence of complicated pneumoconiosis.²² *Ibid.* The sole conclusion reached by Dr. Zaldivar, which is noted in the "comments" section of the report, is that "physiologically there is absolutely no impairment in this case in spite of the diffusion abnormality [*i.e.*, a diffusion capacity consistently shown to be "low" when measured], which remains an isolated value without any physiological significance." *Id.* at 4.

When he was deposed by Claimant's counsel, Dr. Zaldivar agreed that a miner who has complicated pneumoconiosis could also have "perfectly normal physiological studies," including a normal spirometry.²³ CX 6 at 12. He also testified that a physician could not determine whether masses observed by x-ray were caused by tuberculosis or any other cause, and that the only way to diagnose tuberculosis without actually opening the lung would be to perform a bronchoscopy or do a skin test. *Id.* at 13. He did not evaluate Claimant during his examination to determine whether he had tuberculosis, *id.* at 14, he does not conduct TB tests on individuals he examines, *id.* at 21, and he expressed no opinion in his report of examination regarding whether Claimant suffered from that disease.

Dr. Zaldivar testified during his deposition that, based solely on the x-ray obtained during Claimant's examination, Claimant had "simple pneumoconiosis, . . . [with] mass lesions, which [he] thought w[ere] complicated pneumoconiosis and bulla." *Id.* at 6. The "mass lesions" he observed in the x-ray were the basis for his diagnosis of complicated pneumoconiosis. *Ibid.* When asked if he would have diagnosed complicated pneumoconiosis "but for [his] own view of the x-rays in this case," he responded "No." *Id.* at 19.

considered "medical reports" under the applicable regulations, 20 C.F.R. § 725.414(a)(1), they are not discussed further in this decision, although I have considered the opinions of Dr. Scott set forth therein, and have rejected them for the same reasons cited with respect to the opinion of Dr. Wheeler.

²² Employer purportedly offered the report of Dr. Zaldivar designated as EX 1 solely "for the purposes of determining whether or not [Claimant] is disabled," and he objected to Claimant's deposition of Dr. Zaldivar to the extent he was questioned about "the presence or absence of pneumoconiosis, and the type of pneumoconiosis" CX 6 at 5. Since total disability may be based solely on a finding of complicated coal workers' pneumoconiosis under 20 C.F.R. § 718.304, and Dr. Zaldivar's opinion on whether Claimant had complicated pneumoconiosis was directly relevant his opinion regarding whether Claimant was "disabled," I overruled Employer's objection at the hearing and admitted Dr. Zaldivar's deposition testimony as proper rebuttal evidence on the issue of total disability. *See* Tr. 17-15.

²³ This proposition has been acknowledged by the courts in black lung cases. *See, e.g., Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976) (allowing for the possibility of complicated pneumoconiosis without impairment while recognizing the disease "usually produces significant pulmonary impairment"). The statute itself provides benefits to miners with complicated pneumoconiosis even when they are still working. 30 U.S.C. § 923(d); 20 C.F.R. § 725.504(a)(1), (b).

In light of Dr. Zaldivar's acknowledgement that an individual who has complicated pneumoconiosis may also have completely normal pulmonary test results, coupled with his failure to give any explanation regarding why the "mass lesions" he observed in Claimant's chest x-ray would not, by themselves, support a diagnosis of complicated coal workers' pneumoconiosis, I find that his opinion on the issue of whether Claimant suffers from complicated pneumoconiosis is entitled to little weight.

The final opinion on the issue of complicated pneumoconiosis is that of Dr. Wheeler. Dr. Wheeler is clearly a highly qualified physician who is not only a Board-certified radiologist but is a B-Reader who participated as one of four test subjects in the development of the B-Reader test in the early 1970's. EX 13 at 5-6. He testified during his deposition that he reviewed a series of Claimant's chest x-rays spanning a 24-year period between 1980 and 2004. *Id.* at 11, 35-36. Based on his review of all these films, he testified that Claimant had scarring in the apices and upper lungs which "most likely [represents] granulomatous disease as shown by involvement of the pleura, the asymmetrical pattern, and the calcified granulomata." *Id.* at 30.

Regarding whether he believed Claimant had pneumoconiosis at all, Dr. Wheeler testified: "[C]ould some of the nodules in this case be CWP? I guess, but granulomatous disease best explains it." *Id.* at 30. When asked specifically whether he believed Claimant had complicated pneumoconiosis, he testified the location of the large opacities was unusual and more typical of granulomatous disease. *Id.* at 33-34.

Dr. Wheeler testified that the three CT scans done by Charleston Area Medical Center that he reviewed were "non-standard" and thus implied that they were of limited value as a tool for diagnosing pneumoconiosis. *Id.* at 37-40. He acknowledged that some of the radiographic findings he observed "could be pneumoconiosis" and stated that he would defer to the opinion of clinicians and physicians on this issue only when they performed a biopsy. *Id.* at 44, 49.

Dr. Wheeler testified that the primary reason he did not diagnose complicated pneumoconiosis in this case was because Claimant "didn't have very many nodules initially." *Id.* at 51. He testified that complicated pneumoconiosis could only be established by "a radiologic pattern of a mass greater than a centimeter in diameter with a sufficient background of small nodules." *Id.* at 60. He further stated that an individual could not have a large opacity "unless you have a high profusion of background nodules," and he testified that Claimant did not have a high profusion of background nodules which would support a diagnosis of complicated pneumoconiosis. *Ibid.*

Dr. Wheeler disagreed with Dr. Gaziano's statement that the skin test results from the PPD test performed on May 17, 2005 showed that Claimant did not have TB. EX 16. He stated that skin tests for TB may produce a "false" negative for a variety of reasons including age, faulty technique in applying and reading the test, anergy in people who have other diseases, loss of antibodies, and cellular response after tuberculosis has self-cured or been cured by drugs. *Id.* at 1. Dr. Wheeler further believed that the radiographic evidence in this case "showed a progression of upper lung disease that began with possible infiltrate, fibrosis, mass or overlapping bone shadows in right apex and probable nodular infiltrates in lateral periphery upper lobes in 1980 to definite masses involving pleural [sic] containing calcified granulomata

most recent studies.” *Id.* at 2. He stated that the most common reasons for these findings are histoplasmosis and/or TB. *Ibid.* He further noted that

there is overwhelming evidence that the masses in [Claimant’s] series of x-rays and CT scans are large opacities of granulomatous disease, most likely TB by location. Histoplasmosis is another strong candidate assuming a “true” negative PPD and no history of a positive PPD. Other granulomatous diseases (sarcoid, Giant Cell arteritis and Wegener’s) are less common and much less likely to self-cure.

Id. at 3.

I find that Dr. Wheeler’s opinion regarding the issue of complicated pneumoconiosis is entitled to less weight than the better reasoned opinions of Claimant’s experts, particularly that of Dr. Gaziano, for various reasons. These reasons include the following:

First, Dr. Wheeler’s opinion rests principally on his belief that Claimant has, or at one time had, tuberculosis which explains the large masses seen in Claimant’s lungs on x-ray. However, Dr. Zaldivar, one of Employer’s own experts, testified that a physician can not determine whether masses observed on x-ray were caused by tuberculosis and the only way to diagnose tuberculosis without actually opening the lung would be to perform a bronchoscopy or do a skin test. CX 6 at 12-13. Claimant underwent a bronchoscopy and “bronchial wash” in July 2000 which showed that Claimant did not have tuberculosis, and he had a negative skin test for TB in 2005. CX 7; CX 5 at 15-17, 55-56. Claimant also underwent coronary bypass surgery in 1993, twelve years before the negative skin test, which, according to Dr. Wheeler, could not have been performed if Claimant had active tuberculosis.²⁴ EX 13 at 43-44. Indeed, medical records from Claimant’s original claim in 1980 establish that Claimant was found to be negative for the disease over three decades ago, *i.e.*, a discharge summary from Charleston Area Medical Center dated August 24, 1976 shows that Claimant underwent a nasal submucous resection with dorsal reconstruction between July 26 and 30, 1976, during which time he tested negative for tuberculosis.²⁵ DX 1.

Second, I note that Dr. Gaziano, who is Board-certified in pulmonary diseases and internal medicine, is particularly well qualified to express an opinion regarding whether Claimant has ever suffered from tuberculosis. He has served both as a clinician for the Kanawha County, West Virginia TB Program since about 1970 and as the TB Director for the West Virginia Health Department in Kanawha County. CX 5 at 4-7. By his own account, Dr. Gaziano has “treated more TB than any clinic in [West Virginia].” *Id.* at 7. According to Dr. Gaziano, Claimant does not now have, and never has had, tuberculosis. CX 7. He further testified that the

²⁴ Claimant further testified, and the record confirms, that Claimant has undergone other surgeries as well for colon cancer (1994), an ulcerated stomach (1983), and gall bladder removal (1994). Tr. 63-64; DX 1; DX 13. Presumably, treating physicians would have also tested for tuberculosis before performing this surgeries.

²⁵ The summary states, in relevant part, that “[b]oth TB and histo skin tests were applied and were negative. Sputum for culture was negative for AFB [acid-fast bacteria].” Similarly, the report of the DOL medical examination performed by Dr. Gaziano on June 26, 1980 in connection with Claimant’s original claim notes that Claimant underwent a nose operation to remove a bone growth and had a tuberculin skin test which was negative for the disease. DX 1.

x-ray evidence in this case clearly supports a diagnosis of complicated coal workers' pneumoconiosis. See, e.g., CX 5 at 35-36, 50, 69-70.

Third, I note that Dr. Wheeler has repeatedly characterized his diagnoses of TB and other granulomatous diseases in equivocal terms, e.g., "compatible with TB," "can be granulomas [sic] disease," "TB or granulomatous disease is the most likely cause," "compatible with granulomatous disease," "probably healed TB," "most likely granulomatous disease," "either TB or histoplasmosis," and "most likely TB." EX 13 at 11, 19, 26, 28, 29, 30, 52 and EX 16, respectively. In *Cooper v. Westmoreland Coal Co.*, BRB No. 04-0589 BLA (Mar. 28, 2005) (unpub.), the Board held that the presiding administrative law judge properly rejected medical opinions, including one by Dr. Wheeler, when he found that "equivocal identification of TB as the disease process that accounts for the markings that other physicians have identified as complicated pneumoconiosis diminishes [their] credibility." *Id.*, slip op. at 3. Citing *Lester v. Director, OWCP*, 993 F.2d 1143 (4th Cir. 1993), the Board acknowledged that a claimant "bears the burden of establishing that the large opacities are caused by dust exposure." *Ibid.* However, it further noted that, under *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), "in order to resolve conflicting x-ray interpretations regarding the presence of complicated pneumoconiosis, the administrative law judge must assess the probative value of the x-ray readings in their entirety, rather than accepting them at face value." *Ibid.* In this vein, the Board agreed with the presiding judge that equivocal statements regarding etiology were not sufficient to outweigh the opinion of other physicians who concluded that a large opacity was coal dust related. *Ibid.* See, also, *Yogi Mining Co. v. Director, OWCP [Fife]*, Case No. 04-2140 (4th Cir. Dec. 7, 2005) (unpub.) (proper for administrative law judge to accord less weight to equivocal or speculative opinions regarding etiology of opacities measuring greater than one centimeter on chest x-ray especially in light of negative TB tests).

Fourth, Dr. Wheeler has questioned whether Claimant suffers from even simple pneumoconiosis,²⁶ and only reluctantly testified with respect to the present claim that he "guessed" some of the nodules he observed in Claimant's x-rays and CT scans "could be" pneumoconiosis. EX 13 at 30-31. This position ignores the fact that the existence of Claimant's pneumoconiosis was established long ago.²⁷ It also ignores the fact that Dr. Wheeler was among the physicians who previously diagnosed Claimant as suffering from pneumoconiosis based on x-ray evidence.²⁸

²⁶ See, e.g., references in Dr. Wheeler's deposition testimony to Jun. 26, 1980 x-ray ("compatible with TB" but not coal workers' pneumoconiosis or silicosis) EX 13 at 11; Dec. 21, 1992 x-ray ("0/1" profusion of small opacities insufficient to diagnose pneumoconiosis) EX 13 at 18-19; Oct. 3, 1993 x-ray (same) EX 13 at 22; Mar. 21, 2000 x-ray (same) EX 13 at 23; May 12, 2004 x-ray and CT scan (same) EX 13 at 26; and Mar. 19, 2003 CT scan (no evidence of pneumoconiosis) EX 13 at 29.

²⁷ See, e.g., DX 1, July 30, 1982 Decision and Order of ALJ Brown ("The chest x-ray evidence establishes the existence of simple pneumoconiosis pursuant to § 410.428."); April 25, 1985 Decision and Order of Benefits Review Board affirming invocation of interim presumption of total disability based on chest x-ray evidence establishing the existence of pneumoconiosis pursuant to § 727.203(a)(1) ("Because there is no dispute that invocation pursuant to subsection (a)(1) was proper, we need not address claimant's contention that subsection (a)(4) should have been invoked as well.").

²⁸ See, e.g., DX 1 (Oct. 2, 1980 x-ray read by Dr. Wheeler as showing profusion of 2/1 small opacities); DX 3 (Oct. 3, 1993 x-ray read by Dr. Wheeler as showing profusion of 1/0 small opacities).

Fifth, Dr. Wheeler testified that Claimant's chest x-rays failed to reveal "a high profusion of background nodules" in his lungs which might be sufficient to support a diagnosis of complicated coal workers' pneumoconiosis. EX 13 at 60. According to Dr. Gaziano "just about every radiologist that read this man's x-rays [would disagree with that statement]." CX 5 at 50. Indeed, many of the chest x-rays of record have been interpreted by dually-qualified physicians, including Dr. Wheeler, as showing a significant profusion of small opacities consistent with pneumoconiosis.²⁹ Likewise, various B-Readers have similarly found a high profusion of small opacities on Claimant's chest x-rays.³⁰

Finally, Dr. Wheeler testified that, once he has formed an opinion regarding complicated pneumoconiosis based on the available radiographic evidence, he would *only* defer to another physician's opinion if there were positive biopsy evidence. CX 13 at 49. This predisposition to disregard relevant evidence, irrespective of the numbers or qualifications of physicians with contrary opinions, ignores the fact, established by the Department's own regulations, that biopsies themselves are not always reliable indicators of the presence or absence of pneumoconiosis. See 20 C.F.R. § 718.106(c) ("A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis."). Such a predisposition further ignores the fact that the Department's regulations expressly provide that a claimant may establish complicated pneumoconiosis by *any one* of the three alternative provisions set forth in § 718.304, *i.e.*, chest x-ray evidence "or" biopsy or autopsy evidence "or" by other means.

Based on all the foregoing reasons, I find that Dr. Wheeler's opinion on the issue of complicated pneumoconiosis is entitled to less weight than the contrary opinions of Claimant's experts. Given my findings with regard to Employer's other experts, I thus find that the weight of the medical opinion evidence viewed in its entirety supports a finding of complicated pneumoconiosis. I further find, for the reasons previously stated,³¹ that this evidence outweighs the contrary chest x-ray evidence and that the record as a whole demonstrates that Claimant has complicated pneumoconiosis and is irrebuttably presumed to be totally disabled under 20 C.F.R. § 718.304(c). Claimant has thus demonstrated that one of the applicable conditions of entitlement has changed since the date upon which his prior claim was finally denied pursuant to 20 C.F.R. § 725.309(d).

Entitlement Based on Entire Record

Pursuant to 20 C.F.R. § 725.309(d), once a claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, are binding on any party in the adjudication of the subsequent claim. I must therefore determine

²⁹ See, e.g., DX 1 (Oct. 2, 1980 x-ray read by Dr. Wheeler as showing 2/1 profusion of small opacities); DX 2 (Dec. 14, 1991 x-ray read by Dr. Francko as showing 2/1 profusion of small opacities); DX 3 (Oct. 3, 1993 x-ray read by Drs. Scott and Gayler as showing 1/2 profusion of small opacities; Mar. 21, 2000 x-ray read by Dr. Navani as showing 2/1 profusion of small opacities; Jun. 14, 2000 x-ray read by Drs. Gayler and Scott as showing 1/2 profusion of small opacities); DX 13 (May 30, 2002 x-ray read by Dr. Patel as showing 1/2 profusion of small opacities); DX 12 (Jun. 17, 2003 x-ray read by Dr. Smith as showing 2/3 profusion of small opacities).

³⁰ See, e.g., DX 2 (Dec. 14, 1991 x-ray read by Dr. Ranavaya as showing 3/3 profusion of small opacities); DX 3 (Mar. 21, 2000 x-ray read by Dr. Gaziano as showing 2/1 profusion of small opacities and by Dr. Ranavaya as showing 3/3 profusion of small opacities and type A large opacities).

³¹ See discussion *supra* at 25-26, n. 18.

whether all the evidence of record, both new and old, demonstrates that Claimant suffers from pneumoconiosis which was caused, at least in part, by his coal mine employment, and which renders him totally disabled.

Pneumoconiosis

The presence of pneumoconiosis was first established in connection with Claimant's original claim for benefits filed on January 18, 1980. DX 1. That finding has consistently been reaffirmed in subsequent claims. DX 2; DX 3. After a review of the medical evidence submitted in the prior claims, as well as that filed in the instant claim, I find, for the reasons previously stated, that Claimant has established by a preponderance of the evidence that he suffers from both simple and complicated pneumoconiosis.

Causal Relationship of Pneumoconiosis

If a miner suffering from pneumoconiosis was employed for ten years or more in coal mining, there is a rebuttable presumption that such pneumoconiosis arose out of such employment. 20 C.F.R. §§ 718.203(b), 718.302. The relationship of Claimant's pneumoconiosis to his more than 33 years of coal mine employment was first established in connection with Claimant's original claim in 1980, and reaffirmed in subsequent decisions. DX 1-3. There is no evidence in the record which would rebut the presumption that Claimant's pneumoconiosis arose out of his more than 33 years of coal mine employment, and I thus find that Claimant's pneumoconiosis was caused by such employment.

Total Disability and Causal Relationship

As noted above, I have found that the evidence of record establishes that Claimant suffers from complicated pneumoconiosis. Applicable regulations provide an irrebuttable presumption of total disability due to pneumoconiosis where the miner is shown to be suffering from complicated pneumoconiosis. 20 C.F.R. §§ 718.204(b)(1), 718.304. I thus find that Claimant is totally disabled by pneumoconiosis which arose out of his more than 33 years of coal mine employment.

Conclusion

Because Claimant has established a material change in conditions under §725.309, and all of the necessary elements of entitlement, I conclude that he is entitled to benefits under the Act and regulations.

Commencement of Benefits

Benefits are payable in a living miner's claim beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. 20 C.F.R. § 725.503(b). Where the evidence does not establish the month of onset of total disability, benefits are paid beginning with the month during which the claim was filed. *Ibid.* Since the evidence in this case

does not establish the month of onset of total disability, I find that Claimant is entitled to benefits beginning May 2002, the month during which the present claim was filed.

Attorneys Fee

No award of attorney's fees for services to Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §725.365 and §725.366 of the regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

Based on all the foregoing, it is ordered that the claim of S.P.W. for benefits under the Act be, and hereby is, GRANTED.

It is further ordered that the Employer, Peabody Coal Company, shall pay to Claimant all benefits to which he is entitled under the Act, augmented by reason of his dependent spouse, as heretofore specified, commencing May 2002.

It is further ordered that the Employer, Peabody Coal Company, shall reimburse the Secretary of Labor for payments made under the Act to S.P.W., if any, and deduct such amount, as appropriate, from the amount it is ordered to pay under the preceding paragraph.

A

STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).